Mental Health System Transformation Initiative Implementation

Washington State
Department of Social & Health Services

STI Task Force Meeting

March 15, 2007

Outline

1. Mental Health Benefits Package (TriWest)
2. Involuntary Treatment Act Study (AHP)
3. Housing Action Plan (Common Ground)
4. External Utilization Review Project (Harborview)
5. Program of Assertive Community Treatment (WIMIRT)
6. Wrap up and next steps

Washington State System Transformation Initiative

Update on Mental Health Benefits Design Project

Andrew Keller, PhD

March 15, 2007

Report Summary: Preliminary Findings

- Successful EBP/PP implementation requires major infrastructure
  - ✓ Does not work to simply mandate them
  - ✓ Significant limitations in "real world" community settings
    - Proof of **efficacy** in RCT studies does not equal **effectiveness** in practice
    - Research lacking in typical practice setting (with vacancies, turnover, differential staff training, comorbidities)
    - Little consideration of culture, developmental stage, system factors
    - Less research on consumer/family-driven approaches
    - Realistic and unrealistic stakeholder concerns
  - ✓ Need for evidence-based culture at MHD, RSN, provider, consumer / family, community levels
  - ✓ "Centers of Excellence" one way to catalyze

26 Types of Adult / Older Adult Practices

Matrix: Practices by Level of Evidence and Consumer/Family Involvement		
Level of Evidence➔ Family Involvement ⬇	**Well Established Practices**	**Promising Practices**
Consumer / Family Run and Operated	None Identified	▪Drop-In Centers operated by consumer-run organization ▪Peer Support provided by consumer-run organization ▪Wellness Recovery Action Plan (WRAP) facilitated by consumer in consumer-run organization
Consumer / Family Delivered (Full)	▪Family Psychoeducation delivered by family members	▪Drop-In Centers operated by provider organization ▪ICCD Clubhouse ▪Peer Support provided by provider organization ▪Wellness Recovery Action Plan (WRAP) facilitated by consumer in provider organization
Consumer / Family Delivered (Partial)	▪Assertive Community Treatment (ACT) with Peer Specialist	None Identified
Consumer / Family Involvement	▪Family Psychoeducation by professionals ▪Gatekeeper Program ▪Illness Management and Recovery (IMR) ▪Supported Employment	▪Respite Care ▪Supportive Housing ▪Wellness Recovery Action Plan (WRAP) facilitated by professional
Professional Run and Operated	▪Assertive Community Treatment (ACT) w/o Peer Specialist ▪Collaborative Care ▪Dialectical Behavior Therapy (DBT) ▪Integrated Dual Disorder Treatment (IDDT) ▪MedMAP ▪Psychosocial Rehabilitation	▪Case Management ▪Comprehensive Crisis Services ▪Standardized Screening for Substance Abuse Disorders ▪Telepsychiatry

23 Types of Child / Family Practices

Matrix: Practices by Level of Evidence and Family Involvement		
Level of Evidence➔ Family Involvement ⬇	**Well Established Practices (Levels 1 & 2)**	**Promising Practices (Levels 3 & 4)**
Family Run and Operated	None Identified	▪Wraparound Service Coordination facilitated by family member in family-run organization
Family Delivered	None Identified	▪Wraparound Service Coordination facilitated by family member in provider organization
Family Involvement	▪Brief Strategic Family Therapy ▪Cognitive Behavior Therapy ▪Functional Family Therapy ▪Multidimensional Family Therapy ▪Multisystemic Therapy ▪Multidimensional Treatment Foster Care	▪Early Childhood (0-6) Mental Health Consultation ▪Family Integrated Transitions ▪Home Based Crisis Intervention ▪Mentoring ▪Positive Behavior Interventions and Supports ▪Problem Solving Skills Training ▪Respite Care ▪Wraparound Service Coordination facilitated by professional
Professional Run and Operated	▪Applied Behavior Analysis (ABA) ▪Behavior Therapy ▪Cognitive Behavior Therapy (CBT) ▪Trauma Focused CBT ▪Parent - Child Interaction Therapy	▪Dialectical Behavior Therapy (DBT) Approaches for Adolescents ▪Problem Solving Skills Training

Preliminary Findings: Continued

- Current federal climate
  - ✓ Move from Upper Payment Limit (UPL) to Actuarially Sound Rates
  - ✓ Enhanced reporting for State Plan and B-3 services
  - ✓ Enhanced quality standards for managed care plans (42 CFR 438)
  - ✓ Current scrutiny of Rehabilitative Services, DRA of 2005
- This context shaped development of current benefit design
  - ✓ Current Rehab modalities: Quick, successful response to CMS pressure
  - ✓ Access to Care Standards: Response to CMS UM concern/budget limits
- Since then: E2SHB 1290 and the 2005-06 RSN procurement
- New basis of standardization and infrastructure from which to negotiate with CMS

Preliminary Findings: Continued

- Comparisons to four other states
  - ✓ Arizona – Comparable in terms of size, per capita mental health spending (14th compared to Washington at 15th), Medicaid spending, Medicaid members (around 1 million), and a system of regional authorities
  - ✓ Colorado – Less MH spending per capita, but higher Medicaid spending per capita, similar regional organization, similar struggles with encounter tracking
  - ✓ New Mexico – MHTSIG state, but small, 49th in funding, single statewide entity
  - ✓ Pennsylvania – Double population, 20% more Medicaid members, 5 times Medicaid spending (2nd nationally)
- Structural differences between these States and Washington
  - ✓ Other states directly deliver and manage inpatient hospital care
  - ✓ Other states' eligibility requirements center on diagnosis only
  - ✓ Other states define medical necessity separately from eligibility (unlike ACS)
  - ✓ Other states tend not to have small risk pools (under 40,000 covered lives)

Report Summary: Preliminary Findings

- Medicaid State Plan Analysis
  - ✓ State Plan Language
    - Washington's is more highly specified than the other State's plans (eg, specifying hours, units)
    - "Ideal" – Conceptual State Plan, very specific encounter reporting requirements
    - This gives both broadest flexibility with CMS, clearest guidance to providers
    - Arizona, Colorado and New Mexico have taken this approach (Kansas new ideal)
    - PA: Similar design to WA, but less progressive, had to focus on waiver flexibility
  - ✓ Analysis by Modality
    - Quite a bit of flexibility available in Washington's State Plan
    - Still lacking in specific guidance to providers (eg, residential services under 8 hrs)
    - Only completed initial high-level analysis – will complete more thorough analysis for targeted levels of care (see handout)

Report Summary: Preliminary Findings

- Washington Stakeholder Concerns
  - ✓ Input from Forums (February focus group information not yet incorporated)
    - Access for underserved (eg, access to full continuum, cultural/linguistic competency, people needing outreach) (#1), earlier access / early intervention (#4), corrections access (#11) come out on top
    - Consumer / family driven ranked highly (peer support #2, natural supports / Wraparound #5, psychoeducation #6, broad array of supports #7, self-directed care #13)
    - Functional supports: Housing (#3) and Employment (#9)
    - Integrated services: Integrated SA/MH (#10), Integrated Physical Health (#14)
    - Clinical interventions high, but lower priority: Med management (#8), Stabilization Services (#12), High Intensity Treatment Modalities (#15)
    - Fit with MH Transformation Plan findings
    - Nearly all services currently allowable, but infrastructure barriers exist (ACS, rates, Centers of Excellence)

Report Summary: Preliminary Findings

- Washington Stakeholder Concerns
  - ✓ RSN Concerns
    - Access to Care Standards – Generally seen as problematic and/or resource waste
    - Statewideness – Some concern with current requirement; fear of mandated levels
    - EBP development – Proceeding at community level, but major barriers (need for infrastructure, provider capacity and attitudes, rates)
    - Lack of general support among providers for recovery, resiliency focuses
    - Concern with implementing modalities instead of more specific service types
    - Restrictiveness of some modality definitions
    - Paperwork requirements – Especially for intakes
    - Lack of flexibility in use of State-Funded services
  - ✓ State-Level Key Informants
    - Echo same concerns: ACS, statewideness, EBP challenges, paperwork, need for reporting guidance; also priorities on Tribal concerns, service development

Preliminary Report Summary: Recommendations

- Preliminary recommendations
  - ✓ Revise Access to Care Standards
    - Separate eligibility from medical necessity
    - Focus eligibility on diagnosis, not functioning; have just one diagnosis list
    - Develop statewide medical necessity standards, with option of RSN-level flexibility
    - EBP development – Proceeding at community level, but major barriers (need for infrastructure, provider capacity and attitudes, rates)
  - ✓ Revised current contract expectations for statewideness
    - Shift focus from statewideness (42 CFR 41.50) to also include network adequacy (42 CFR438.206, 207)
    - Require RSNs to show how needs are documented and met, rather than simply demonstrate that the network includes a provider for each modality

Preliminary Report Summary: Next Steps

- Items for Discussion Today
  - ✓ Get input on desired scope of benefit design recommendations: Top 5 lists or 50?
  - ✓ Get input on criteria for prioritization:
    - Inpatient reduction
    - Recovery / resiliency promotion
    - EBP promotion
    - Cost-benefit
    - "Low Hanging Fruit"
    - Other?
  - ✓ Get input on next steps for major stakeholder groups: consumers, parents, families, providers, RSNs, allied systems

Preliminary Report Summary: Next Steps

- Next Steps After Today
  - ✓ March and April
    - Gather additional input from stakeholders
    - Carry out analysis (including start of cost analysis) of priority best practices
    - Begin to develop implementation plan
    - Prepare recommendations for May forum
    - Separate track for Tribal Government concerns and issues
  - ✓ May and June
    - Feedback on specific recommendations at May multi-stakeholder forum
    - Finalize recommendations with MHD

Washington State System Transformation Initiative: *Review of Involuntary Treatment Laws*

March 15, 2007

Jenifer Urff, J.D.
Advocates for Human Potential, Inc.

Guiding Principles and Scope of Review

- MHD's desire to create a recovery-focused, resiliency-based system of care
- Specific focus on civil commitment issues affecting community and State hospital utilization
  - Review specific provisions in State involuntary treatment statutes
  - Compare specific provisions with other states' approaches
  - Identify strengths, challenges, and options for reform

Preliminary Findings

Broad range of perspectives regarding involuntary treatment and civil commitment

Make civil commitment more available as a mechanism to divert people who will otherwise be involved in the criminal justice system

Lower the threshold for commitment under the grave disability standard to make getting help easier

Narrow civil commitment laws to ensure that everyone who is civilly committed can benefit from hospitalization

Raise the threshold for commitment under the grave disability standard to promote civil rights and minimize the use of inpatient services

Preliminary Findings

Broad consensus on key issues:

- Use of civil commitment reflects a lack of appropriate, recovery-oriented services in the community
- Actual statutory language has less impact on the use of civil commitment than other factors, especially the lack of housing and community residential options
- Most important statutory issue is definition of “mental disorder”

Focus of Review

- Definition of “mental disorder”
- Definition of “gravely disabled”
- Age of consent/parent-initiated treatment
- Forensic conversion and other issues addressed through other initiatives
- Tribal implications to be addressed
- Other issues identified for future research

Key Issues and Analysis

Three key issues for analysis:

- Definition of “mental disorder”
- Definition of “gravely disabled”
- Age of consent/parent-initiated treatment for children and adolescents

Key Issues and Analysis

Civil Commitment Criteria:

- Mental disorder *and*
- Likelihood of serious harm (substantial risk of physical harm to self, others, or property of others) *or*
- Gravely disabled

Definition of Mental Disorder

Washington:

> "Mental disorder" means ***any organic, mental, or emotional impairment*** which has ***substantial adverse effects*** on a person's ***cognitive or volitional*** functions
>
> *Wash. Rev. Code 71.05.020(22)*

Definition of Mental Disorder

- No uniform approach or “best practices” model
- No specific legal or medical definitions to rely on
- All states use different definitions to reflect structure of services systems and policy objectives

Definition of Mental Disorder

Strengths:

- Breadth of definition provides flexibility
- People who meet civil commitment criteria receive services regardless of diagnosis or disorder

Challenges:

- Many people committed to inpatient psychiatric services cannot benefit from services in that setting
- Inpatient services become providers of last resort when other service systems fail to provide needed services and supports

Definition of Mental Disorder

Options for Reform:

- **Change "mental disorder" to "mental illness and define mental illness more narrowly**
  - *Example* – Pennsylvania: Mental illness is those "disorders that are listed in the applicable APA Diagnostic Manual.
- **Specifically exclude people with developmental disabilities or other conditions from the definition of "mental disorder"**

Definition of Mental Disorder

- *Example* – Arizona: Mental disorder means a substantial disorder of the person's emotional processes, thought, cognition or memory. *Mental disorder is distinguished from:*
  - (a) Conditions that are primarily those of drug abuse, alcoholism or mental retardation, unless, in addition to one or more of these conditions, the person has a mental disorder.
  - (b) The declining mental abilities that directly accompany impending death.
  - (c) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder.

Ariz. Rev. Stat. 36-501(26)

Definition of Mental Disorder

Discussion:

- Implications for people who may need services and otherwise meet civil commitment criteria
- Implications for other service systems
- Ways to address these challenges and concerns

Definition of Gravely Disabled

Washington:

"Gravely disabled" means a person is:

- In danger of ***serious physical harm*** resulting from a failure to provide for his or her essential human needs of health or safety; or
- Manifests ***severe deterioration in routine functioning*** evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions; and
- Is not receiving ***such care as is essential*** for health or safety.

Wash. Rev. Code 71.05.020(16)

Definition of Gravely Disabled

- No uniform approach or “best practices” model
- About half the states, like Washington, do not require that a person be unable to meet essential needs such as food, shelter, or protection in the community in order to be civilly committed
- All states impose different criteria

Definition of Gravely Disabled

Strengths:

- Permits civil commitment of people who are experiencing a severe deterioration in functioning without requiring that they become dangerous to themselves or others
- Permits flexibility:

  "A common theme here is that even though the grounds for commitment are present, a DMHP does not necessarily need to detain. However, if you shrink the available grounds for commitment, a DMHP will be unable to detain, even when the need to detain is great."

Definition of Gravely Disabled

Challenges:

- About 62 percent of people detained in FY2006 were considered to be “gravely disabled” (although many may also have met other commitment criteria)
- Broader than most states, even those with similar “need for treatment” statutes
- Some consumers feel that they were detained principally because they were homeless, and that broad definition provides too much flexibility when there is no danger

Definition of Gravely Disabled

Options for Reform:

- **Repeal part B of the statute, which permits commitment even when essential needs are met if the person is experiencing a severe deterioration in routine functioning and is not receiving care essential for his or her health or safety**

Definition of Gravely Disabled

- **Modify part B to:**
  - **Permit commitment only when the person is unable to make their own informed judgment about treatment** (Arizona)
  - **Permit commitment under part B only if the person's deterioration is likely to result in their meeting other commitment criteria** (Oregon's statute requiring a showing that, "to a reasonable medical probability," the deterioration will continue until the person meets other statutory criteria)
  - **Permit commitment only if the person's deterioration is likely to result in the person requiring involuntary hospitalization based on prior experience** (Oregon's statute)

Definition of Gravely Disabled

Discussion:

- Implications for consumers
- Implications for other stakeholder groups
- Implications for other services systems (inlcuding criminal justice)
- Ways to address these challenges and concerns

Age of Consent/ Parent-Initiated Treatment

Washington:

- A minor 13 years or older may receive outpatient mental health services or admit themselves to an evaluation and treatment facility for inpatient treatment without parental consent.
- A parent may take a minor child to an appropriately licensed facility and request examination and admission as an inpatient.
- Minors will not have a cause of action against the facility for admitting the minor in good faith based solely on their not consenting to treatment if their parent did consent.

Wash. Rev. Code 71.34

Age of Consent/ Parent-Initiated Treatment

Question for Additional Research: Why is Parent-Initiated Treatment not used?

Possible Explanations:

- Lack of clarity regarding due process procedures for minors who do not consent
- Concern regarding independent reviews of provider admission decisions

Age of Consent/Parent-Initiated Treatment

Discussion:

- Why is parent-initiated treatment, as permitted by statute, not utilized more frequently?
- Implications for adolescents and families of greater utilization of parent-initiated treatment
- Implications for adolescents and families of increasing age of consent

Tribal Concerns and Implications

- Separate chapter on tribal implications considered for Final Report
- Tribal concerns:
  - No ability to detain; referrals to RSNs are not accepted
  - State does not contract directly with Tribes to provide services
  - No involvement in discharge planning so no continuity of services
  - Lack of cultural competency in conducting evaluations and providing services

Other Important Issues

- Involuntary Medication
  - "Second signature" issue: Permit involuntary medication of individuals receiving short-term treatment up to 30 days under civil commitment if two concurring medical opinions
  - Very important to consumers and legal advocates; others agree that law may present constitutional issue
  - Possible reforms range from never permitting involuntary medications without advance directives to requiring hearings in non-emergencies

Other Important Issues

- Definition of Likelihood of Serious Harm
  - Permits civil commitment where "physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others."
- Advance Directives
  - RCW 71.32 provides for mental health advance directives, but says they won't apply when a person is civilly committed
- Training for DMHPs

Other Important Issues

Discussion:

- Which issues are priorities for future research?
- What other issues should be identified for future research?

Next Steps

- Better representation from Eastern side of Washington State
- Explore age of consent/parent-initiated treatment issues
- Tribal study

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Mental Health Housing Plan

STI Task Force Meeting

March 15, 2007

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Housing Plan Creation

Preliminary Plan

+

Housing Action Plan (april)

=

Final Housing Plan (june)

Preliminary Plan

- Philosophy
- Models
- Partnerships
- Financing
- Building capacity
- State policies and tools

PP Models

- **Permanent Supportive Housing (PSH)** (no limits on tenure and supporting services titrated to meet needs of consumer overtime)
- **Housing First** (direct placement into PSH and housing not conditioned on accepting services or sobriety)
- **Mix of leased and developed units**
- **Range of housing types** (SROs, apartments, single family homes, group homes, assisted living facilities)

PP Partnerships

- **Between state agencies for policy and resources** (for example, CTED, DSHS/MHD)
- **Between hospitals and supportive housing providers** (for example, diversion programs from hospital ERs or temporary stays while apartments are held)
- **Among service providers, housing providers, consumers/residents** (for example, master leases between housers and service providers or incentive programs for landlords, or contracts with consumer organizations for peer support)

PP Financing

- **Tapping existing housing funds** (HUD Mckinney and 811, CBDG, HOME, HTF, LIHTC, state and local 2060 and 2163, Section 8, TBRA, local $)
- **Using existing housing stock** (section 8, TBRA, state and local 2060, state and local 2163)
- **Using existing service dollars** (PACT, PHP contracts, state only contracts, 2163 state and local)
- **Exploring new financing** (.1% local levy, cost shifting from local and state criminal justice systems, private foundation support)

PP Building Capacity

- **MHD** (dedicated staff person for housing)
- **CTED** (providing TA at county and provider level to expand services and housing for homelessness people, including people with mental illnesses)
- **RSN / provider** (providing training and individual TA)
- **PACT** (integrating training on housing into PACT training)

PP State Policies and Tools

- DSHS/MHD - CTED/Housing Division coordination
- RSN and provider contracts
- Medicaid benefit design

Housing Action Plan

- Specific unit targets and financing plan for 500 units by 2010
- Projected targets, funding sources and uses for additional 750 units by 2015

HAP Unit Targets for 500

- Leased vs. developed
- Geographic priorities
- Subpopulation priorities
- Models

HAP Financing plan for 500 units

- Capital $
- Operating $
- Service $
- Vouchers

HAP Capacity Building for 500 units

- State strategies
- Regional strategies
- Local strategies

HAP Assumptions for Another 750 by 2015

- Policy decisions
- Funding requirements
- Capacity building needs

Discussion Items

a. How do we set geographic and subpopulation priorities for the 500 units?

b. Can we provide necessary services, within existing resources, for PSH?

c. What are the best ways to build capacity for PSH?

Geographic Priorities

- PACT locations?
- County Homeless Plan priorities?
- RSN Housing plans?
- Large vs small counties?
- East vs West balance?
- Other?

Subpopulation priorities

- **RSN Housing Plan?**
- **County Homeless Housing Plan?**
- **County Consolidated Plan?**
- **Other?**

PSH within Existing Service $

- **PACT?**
- **PHP contract?**
- **State only contract?**
- **(average $6,000-10,000 per year depending on severity of needs)**

Building Regional and Local Capacity

- Trainings linked to existing conferences and meetings?
- Small capacity building grants to selected RSNs?
- Training integrated with PACT roll out?
- Individual onsite TA for providers?
- Phone consultation to RSNs and providers?
- Consumer trainings?
- Other?

Utilization Review Project

- Harborview Medical Center
  - Brigitte Folz MSW LICSW
  - Joellen Watson PHD
  - Darcy Jaffe ARNP
- Department of Psychiatry
  - Toni Krupski PHD
  - Peter Roy-Byrne MD

Overview of Purpose

- Review process and practice of UM in state and community hospitals by RSNs and MHD.
  - Medicaid client population served in community hospitals
  - All client populations served by State Hospitals.
- Compare and analyze practice across the RSNs and state hospitals
- Develop options and recommendations for improvements

Project Methods and Activities

- Integration with other projects as part of the System Transformation Initiative.
- Analysis and review of current practice via P&P review, data review and...
- Stakeholder interviews.
  - RSN and subcontractor key informant interviews
  - Consumer focus groups at State Hospitals and in community settings
  - NAMI and family members
  - Tribal representatives and organizations
  - MHD staff
  - State and community hospital staff

Project Methods and Activities (Continued)

- Peer State Analysis
  - Impact of ITA laws and processes
    - Criteria and process of commitment
    - Treatment alternatives for specialized populations
    - Resource and housing alternatives
    - Alternative legal processes or other resources for special groups; IE. Dementia and TBI
  - Utilization Oversight Comparison
    - LOS (if available)
    - Internal versus external UR structure
    - Level of reporting within State structure
  - Medicaid Benefits comparison

Project Methods and Activities (Continued)

- Peer State Options (Yet to finalize)
  - ITA Project Peer States
    - Oregon, Pennsylvania, Arizona and California
  - Medicaid Benefits Design Peer States
    - Pennsylvania, Arizona and Massachusetts
  - OTHER?

Project Methods and Activities (Continued)

- Review History of UR Practice
  - Historical Context via Literature review
  - Current Practice Across Payors
    - Private Insurers
    - Medicare
    - Medicaid
  - Best Practices
  - Review of principles
    - Standards and criteria for levels of care
    - Evidence based treatment at appropriate level.

Challenges in Planning for an External Review

- Legal ITA process frequently not congruent with UR processes.
- Behavioral/Legal criteria and the “medical ” treatment models may conflict.
- Consumers, who are hospitalized against their will under ITA processes, highlight engagement and resource problems as well as process of illness or disability.
- Long term disability and Medicaid eligibility criteria may conflict with recovery model goals.
- Unfunded and underfunded populations in hospitals may be vulnerable to resource gaps that cause usage of state hospitals.
- Integrate non-coercive and recovery based systems of care with a medical care management model (UR)
- Other

The Basics – Managing Hospital Utilization

- "The right care at the right time".
- Develop a UR system that will be resilient and sensitive to changing consumer and community needs which will feed back accurate information to MHD.
- Develop accurate information about the medical and psychiatric acuity of patients in the community hospital and ITA systems.
- Going forward – getting the best information about resource gaps to those who can make a difference.
- Ensure high quality evidence based practice which is medically necessary to assist with patient's recovery
- Management of admissions, Length of stay, appropriateness of treatment, treatment goals and discharge criteria.

Feedback

- What else should we consider?
  - Vision
  - Data
  - Stakeholders
  - Resources

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Washington State
System Transformation Initiative

PACT Implementation
Task Force Update

March 15, 2007

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Update Overview

1. Update on current PACT implementation
2. Feedback on new program fidelity domains
3. Brief overview of Training and TA Plan

Status of WA PACT Implementation Today

- Training of RSNs, providers, and key stakeholders (Feb.)
- All Western RSNs selected providers (Completed in Feb.)
- Reviewed Eastern RSNs' implementation plans and provided feedback (completed in March)
- TA to Western RSNs & providers (Jan. – March)

What's Next

- Continue with TA for both Western and Eastern RSNs and providers
- Development of fidelity assessment tool
- Finalization of Training & TA Plan and schedule for Western RSNs

PACT Fidelity Assessment Measure Development

The Value of Program Fidelity

...the extent to which program practices adhere to the principles of the intended program model

- Critical for replication
- Essential for true interpretation of outcome
- Helps to identify/prevent model drift
- Useful for performance improvement & supervision

What do we know about the value of PACT fidelity?

- Consumers and staff in PACT programs with *greater* fidelity experienced *better* outcomes

- McGrew & colleagues (1994) found that reduced hospital use was correlated with:
  - Shared caseloads
  - Nurse on team
  - Daily team meetings
  - Team leader as practicing clinician
  - Total contacts

More about PACT fidelity

- McHugo & colleagues (1999) examined consumer outcomes in 7 PACT teams
- Consumers served by high fidelity PACT teams experienced:
  - Fewer hospitalizations
  - Fewer treatment dropouts
  - Greater remission from substance use

Approaches to PACT Fidelity Measurement

- Comparison between PACT team and state's PACT program standards (e.g., OK)
- Model Fidelity Review of the PACT National Standards (Allness & Knoedler, 2003)
- Dartmouth ACT Scale (DACTS; Teague et al., 1998)

The DACTS
(Teague et al., 1998)

- Assesses 28 domains
- Examines structure, staffing, organizational components, and nature of services
- Anchored ratings between 1 (“not implemented”) and 5 (“fully implemented”)
- Ratings based on *current* activities and status
- Completed by external reviewers or internal agency or team

DACTS Items

Human Resources: Structure & Composition

- Small Caseload
- Team Approach
- Program Meeting
- Practicing Team Leader
- Continuity of Staffing
- Staff Capacity
- Psychiatrist on Staff
- Nurse on Staff
- Substance Abuse Specialist on Staff
- Vocational Specialist on Staff
- Sufficient Program Size

DACTS Items

Organizational Boundaries

- Explicit Admission Criteria
- Low Intake Rate
- Fully Responsible for Treatment Services
- Responsible for Crisis Services
- Responsible for Hospital Admissions
- Responsible for Hospital Discharge Planning
- Time-Unlimited Services

DACTS Items

Nature of Services

- Community-Based Services
- No Dropout Policy
- Assertive Engagement Mechanisms
- High Service Intensity
- High Frequency of Contacts
- Work with Informal Support System
- Individualized Substance Abuse Treatment
- Dual Disorder Treatment Groups
- Dual Disorders Model
- Consumers on Team

DACTS Example Items

Domain	1	2	3	4	5
Small Caseload	50 clients per team member or more	35-49	21-34	11-20	10 clients per team member or fewer

DACTS Example Items

Domain	1	2	3	4	5
Responsible for Crisis Services	Not responsible for handling crises after hours	Emergency service has program-generated protocol	Program available by phone; consult role	Program provides emergency service backup	Program provides 24-hour coverage

Limitations of the DACTS

- Mainly assesses structure vs. processes or principles within the team
- Original purpose to assess a COD-ACT team
- Doesn't match up with National PACT Program Standards (i.e., WA PACT Standards)
- Includes virtually nothing about person-centered, recovery-oriented processes

Approach to WA PACT Fidelity Assessment

- Use the DACTS template and approach
  - Utility in using an anchored scale vs. “is it there or not” approach
  - Much of the existing DACTS is useful
  - Many other states still use the DACTS -- only scale out there
- Crosswalk WA PACT Standards with DACTS
  - Modification to some domains/anchors on staffing
  - More clarity in domains identified as problematic

Approach to WA PACT Fidelity Assessment

- Add items related to core PACT processes, for example:

Core PACT Services	Consumer Choice
Strengths-Based Assessment	Service Individualization
Person-Centered Planning	Consumer Empowerment

- Tap a broader range of perspectives
  - Consumers
  - Natural supports
- Use for ongoing performance improvement and supervision

Contextual Considerations

- Parallel assessment of PACT implementation (i.e., evaluate key factors for successful implementation)
- Some overlap with outcome assessment, especially recovery indicators
- Balance trade-off between more essential info vs. increased time/burden

Where We're At Today

- Finishing as we speak: Crosswalk between the WA PACT Standards and DACTS (pending any final changes to the WA PACT Standards)
- Need stakeholder input on addition of core PACT processes
- Stakeholder input from STI Task Force & key informant interviews

Additional Domains Under Consideration

1. Core PACT Services
2. Strengths-Based Assessment
3. Person-Centered Planning
4. Consumer Choice
5. Service Individualization
6. Consumer Empowerment

Core PACT Processes

PACT Services **(WA PACT Standards 2/21/07)**

- Service Coordination
- Crisis Assessment & Intervention
- Recovery/Symptom Management
- Medication Services
- Dual Diagnosis Substance Abuse Services
- Work-Related Services
- Activities of Daily Living Services
- Psychosocial Skills Training
- Peer Support & Wellness Recovery Services
- Support Services
- Education & Support to Families/Natural Supports

Core PACT Processes (cont.)

- Strengths-Based Assessment (Tondora & Davidson, 2006)
  - A discussion of strengths is a central focus of every assessment; perceived deficits are interpreted within a strengths/resilience framework
  - Language is in the consumer's own words
  - Includes assessment of areas not traditionally considered "strengths" (e.g., most significant or most valued accomplishments, ways of relaxing or having fun, ways of calming down when upset, personal heroes, etc.)
  - The diversity of strengths that can serve as resources for the individual are respected

Core PACT Processes (cont.)

- Person-Centered Planning (Tondora & Davidson, 2006)
  - Staff actively partner with the individual in all planning meetings regarding his/her recovery services & supports
  - Goals are based on the individual's unique interests, preferences, and strengths; objectives and interventions are clearly related to attainment of these stated goals
  - A wide range of interventions & contributors to the planning process & services are recognized & respected
  - Community inclusion/integration is valued as a commonly identified & desired outcome

Other Recovery Indicators

- Consumer choice (GOI, Lynne et al., 2005)
  - Individuals receiving PACT services are offered choices; PACT staff consider and abide by consumer preferences for services when offering and providing services
- Service individualization (Paulson et al., 2002)
  - Services are tailored to meet consumer needs and preferences
- Consumer empowerment (Paulson et al., 2002)
  - Consumers have the authority to choose from a range of options and to participate in all decisions
  - Staff expect and encourage individual consumers to conduct their day-to-day activities/tasks for themselves

What else do you think is essential to PACT?

For more information:

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